UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

REQUEST FOR MEDROXYPROGESTERONE ACETATE
(generic Depo Provera)
For Non-Traditional and PCN Clients

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

---

FAX THIS COMPLETED FORM TO 855-828-4992

CRITERIA FOR MEDROXYPROGESTERONE ACETATE:

Patient or provider request injectable medication for family planning.

NOTES:

This form is for Non-Traditional clients (blue card) and Primary Care Network (yellow cards) only. Traditional clients (purple card) may receive this medication without a Prior Authorization. Please bill with J-code J1055. and an appropriate NDC.

AUTHORIZATION:

1 year.

RE-AUTHORIZATION:

Updated letter of medical necessity

02/06/2014

http://health.utah.gov/medicaid/pharmacy